TRENDS IN PUBLIC HEALTH PRACTICE IN INDIA

A PLEA FOR A NEW PUBLIC HEALTH

By

DEBABAR BANERJI

Professor & Chairman

CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH

SCHOOL OF SOCIAL SCIENCES

JAWAHARLAL NEHRU UNIVERSITY

NEW DELHI-110 067, INDIA

B. C. DASGUPTA ORATION

THIRTY-SECOND ANNUAL CONFERENCE OF THE INDIAN PUBLIC HEALTH ASSOCIATION

HYDERABAD, FEBRUARY 5—7, 1988.

CPHE

A PLEA FOR A NEW PUBLIC HEALTH

CPHE
D.C.
89

INTRODUCTION

An Important feature of health policies, plans and programmes in India is that they originated during the national movement against colonial rule. The National Planning Committee of the Indian National Congress was set up in 1938 (National Planning Committee 1949). The then President of the Congress, Subhash Chandra Bose, nominated Jawaharlal Nehru, Chairman of the Committee. This Committee set up Sub-Committee on National Health (Sokhey Committee) which made a penetrating assessment of the then health situation and health services in the country and recommended measures for their improvement.

The Health Survey and Development Committee, generally referred to as the Bhore Committee (Government of India 1946b), though it was set up by British colonial authorities (1943), was greatly influenced by the aspirations of the national movement. In fact, several of its influential members had been in the forefront of the struggle for independence. The Committee's impact is also clearly seen in the shaping of health services in independent India.

In following the policy frame for health services which had begun to take shape during the freedom movement, independent India embarked step by step on implementation of a comprehensive rural health service through Primary Health Centres, health planning as part of the national socio-economic plan, mass campaigns against communicable diseases, social orientation of education and training of health workers of various kinds, population control through a national programme for integrated family planning, promotion of indigenous systems of medicine, provision of adequate protected water supply, environmental sanitation, and nutrition programmes.

These trends culminated in the launching of the Multipurpose Workers Scheme in 1972 (Government of India 1973), aimed at providing entire packages of health services through male and female multipurpose workers. In 1977, the Rural Health Scheme for entrusting 'People's Health in People's Hands' (Government of

India, 1978), through health workers chosen by the community, was launched. India can thus be said to have generally anticipated the primary health care approach adopted by the international conference on this subject organized by the World Health Organization and UNICEF at Alma Ata in 1978 (World Health Organization, 1978).

Adoption of such programmes posed a very difficult challenge to public health practioners of the country. It was something new in public health, with very little precedence to go by. It called for major innovations in public health practice. A very important task was to develop epidemiological competence to come to grips with the massive public health problems of the country. The problems had to be understood in its entirety. Appropriate technological packages had to be developed. A suitable delivery system had to be worked out to provide coverage the entire population. Community participation had to be promoted by bringing about social orientation of technology and of the health care delivery system. On the other side, there was the severe limitation of resources of all kinds, vastly different socio-cultural and ecological conditions and a somewhat fragile political and administrative structure.

One of the most startling anomalies in health service development in India is that, instead of the needed improvement, there has been a steady decline in the quality of public health practicesince India gained Independence. What went wrong? Why did this happen? What should be done? Answers to such questions form the subject matter of this presentation. For this, growth and development of health services had been studied both in the colonial and post-colonial contexts.

COMH 340

II

FORMATION OF THE HEALTH SERVICES

An historical analysis of health service development in India during the colonial and post-colonial periods has underlined the important role of certain intrinsic socio-cultural forces which set a limit to possibilities of political action and purposive interventions to improve health services. These socio-cultural processes are embeded in the historical and ecological conditions of the country(Banerji, 1986a: 148-50). Impact of Western medicine on the pre-existing health culture, ecological consequences of colonial exploitation and plunder, limiting access of Western medicine to specific classes, using struggle for health as a component of the overall anti-colonial struggle and the post-independence changes in the power structure and their implications for health service development, are some of the issues which fall in this category.

Some of the important features of the contemporary health services are rooted in their origin, growth and development during the colonial period:

1. At the time of the colonial conquest, the colonial army and the civilian rulers suffered from exceedingly high rates of morbidity and mortality due to communicable diseases, like 'fever','diarrhoeas' and 'dysentery and cholera'(Ramasubban, 1982:11). The average annual mortality rate among European troops during 1817-1857 was as high as 69 per thousand with as many as 85 per thousand were reportedly to be constantly in hospital.

2. The colonial rulers introduced the practice of the Western (allopathic) system of medicine with the declared aim of reducing the morbidity and mortality rates among the European military and civil personnel serving the Empire.

3. Until the second decade of the twentieth century, the native population had virtually no access to the government sponsored health services, while the acute conditions of hunger and poverty and the very degrading living conditions made them much more vulnerable to different diseases. They were also victims of waves massive epidemics (e.g. cholera, plague, smallpox and malaria) and periodic famines, which caused deaths in tens of millions.

4. The last hundred years of the colonial rule also saw fundamental breakthroughs in the fields of medicine and

public health in the West-Tantisepsis, the sanitary movement, discovery of bacteria and viruses, vaccines, chemotherapeutics, antibiotics and potent insecticides.

5. The anti-colonial movement had become strong enough to force the colonial rulers to make available some health services to the native gentry, which formed a thin upper crust of the population.

6. Even this manifestly limited increase in the access of the government health services to the segment of the native population brought into sharp focus the important anthropological issue of interraction between the pre-existing, culturally determined perceptions and meanings of health problems, health institutions, health practices and health behaviour, on the one hand and those which were sought to be introduced by the exponents of Western medinecine,on the other.

The major landmarks in the growth and development of the health services in India ought to be seen against the background of interaction of two or more of the above considerations over a time dimension. These landmarks are:

1. Setting up of medical colleges along with the teaching hospitals in the presidency cities around 1835.

2. Appointment of a Royal Commission to enquire into the health of the army in India in 1959 (Ramasubban, 1982:13-15). Inspired by the sanitary movement in Europe, initiated about that time by pioneers like Edwin Chadwick, John Simon, Rudolf Virchow and John Snow, the Royal Commission worked out in details the norms to be followed for the creation and development of exclusive areas of residence for Europeans. For this purpose, regulations were enacted to regulate residence in specially demarcated areas like, 'cantonments', 'civil lines','civil stations' and 'hill stations'. This, in effect, amounted to both social and physical segregation of the Europeans from the native population and this also included segregation of other British soldiers from the native sepoys by having separate 'native lines' in cantonments. Hospitals or wards were set aside exclusively

for the benefit of the Europeans. Such blatant discrimination on racial lines continued to be a component of public health practice right upto the end of the British rule in India.

The Royal Commission also made recommendations concerning the civilian (exclusively or mostly European) populations and Commissioners of Public Health were appointed in the Provinces of Madras, Bombay and Bengal in 1864.

3 In 1888, the Government of India (19946a:23) issued a resolution for the municipalities in cities and local bodies in orural areas, drawing their attention to their duties in the matter of sanitation. However, the impact was negligible, because medical administrators did not attach importance to preventive medicine(Government of India 1946a:23).

4. Another effort was made to further strengthen the public health services following the report of the plague Commission of 1904 (Government of India 1946a:23). This led to establishment of laboratories for research and for preparation of vaccines and sera, establishment of the Medical Research Department and the Indian Research Fund Association and addition of a post of Deputy Sanitary Commissioner under provincial governments and health officers in local governments. However, the impact of these changes was restricted to limited populations in urban areas(Government of India 1946a:23).

5. Responding to the increasing tempo of political agitation, the Govoernment of India(19946a::21-25) promulgated the Acts of 1919 and 1935 to concede some degree of involvement of people in government. This was associated with the transfer of most of the responsibilities in the field of 'medical relief and public health' to popular provincial health ministries. Even this manifestly limited popular participation in the government led to remarkable developments in the health services, both quantitatively as well as qualitatively. It was possible to implement the recommendations of the various commissions of the nineteenth century, resulting in the placement of trained public health staff in some urban and even in a few rural areas. Even though very much more needed to be done in meeting the most

elementary needs of the people of the country, the real significance of the changes following the Acts of 1919 and 1935 was that it provided a decisive evidence of the linkage between health, health service development and socio-economic and political changes. Increasing intensification of the anti-colonial struggle and outbreak of the World War II gave a major boost to socio-economic and political changes. One outcome of these changes was the formation of an ambitious blue-print for health service development in India on the basis of the reports of the National Health Subcommittee of othe National Planning Committees(1948) of the Indian National Congress(Sokhey Committee) and the Health Survey and Development (Bhore) Committee of the Covernment of India (1946b).

By the time India attained Independence, the interplay of political, economic and social forces had created an ecological setting conducive to very widespread prevalence a high incidence of a variety of diseases. In the course of the two hundred years of colonial rule, almost every facet of life in India was subordinated to the commercial, political and administrative interests of the ruling power (Banerji 1985a:9).

The country was very backward in both agriculture and industry. Class, caste and religion had helped divide society into a very tiny minority of highly privileged persons at one extreme and a huge mass of underprivileged and exploited people at the other. India was (and unfortunately continues to be) a desperately poor country. The poor suffered intense hardships: hunger and malnutrition were almost universal; milk for most children was an unattainable luxury; half the children born to a woman died before she completed her child bearing period; clothing consisted mostly of rags which barely covered the body; dilapidated huts in grossly insanitary surroundings served for dwellings; more than nine-tenths of the population was illiterate and, of the few children who were sent to school, the great majority dropped out well before they could complete even four years of schooling (National Planning Committee 1948:19; Banerji 1971a:33).

Despite the changes following the Acts of 1919 and 1935, the

picture of the health services was still very gloomy. On the eve of Independence, medical services were scattered and highly inadequate, not only in number but in the kind of medical care they delivered. Rural populations in particular were starved of services. On an average, 45,000 people in rural areas were served by one medical institution. The distribution varied widely in different provinces: the ratios in the United Provinces was as much as 105,626 people inhabiting in 202 villages, while it was 23,658 in Sind. The total number of beds available was about 70,000, a ratio of 0.24 bed per 1,000 people. The same dismal picture existed with regard to health personnel: a ratio of one doctor to 6,000 population, one nurse to 43,000, one health visitor to 400,000, one midwife to 60,000, one qualified pharmacist to 4,000,000 and one dentist to 300,000 (Government of India 1946b:5). Within each province, again conforming to the colonial pattern, both the personnel as well institutions were concentrated around the civil lines and civil stations. It is significant that the guiding force in establishment of civil hospitals at the district headquarters and in other administrative FOCI in the district was to provide medical care facilities to the personnel of the district administration. Thus, while some natives did benefit from the facilities made available at civil hospitals, one of its prime duties was to provide support to the 'steel frame' of the colonial administration in the form of offering health services to those living in far flung civil lines and civil stations.

There were enormous shortfalls in health officers and public health units even at district headqauarters and in municipalites. At the time of Independence, as much as half of the districts and three quarters of the municipalities in British India did not have qualified health officers (Government of India 1946b:47). Barely 236 qualified health officers were posted in rural areas and the number posted in urban areas was 201. It may also be noted as many as two-fifths of these were medical lincenciates. There were only 32,976 sanitary inspectors, forming a population ratio of one for 100,000.

III

THE INDIAN MEDICAL SERVICE

Just as the Indian Civil Service provided the 'steel frame' of the civil administration in British India, the Indian Medical Service (IMS) provided the 'steel frame' for the administration of medical, public health and medical education, training and research services, covering both the civil and military populations. There was a separate cadre - the British Army Medical Department, which was later redesignated as the Royal Army Medical Corps - for the British Army stationed in India (Ramasubban 1982:31). However, it was the IMS which dominated the scene. If the military and civil organizations are meant to perform 'line' functions for colonisation and colonial administration of the country, then the organizations run by the Indian Medical Services can be considered as performing 'staff' functions to support the 'line' activities. As would be pointed out later on, assignment of this role to the IMS has had far reaching implications for the growth and development of civil and military health services in British India.

Personnel of the Indian Medical Service (IMS) of the British Indian Army played a key role in framing a colonial pattern of health services of India. The Indian Medical Service embodied all the shortcomings of a colonial medical service (Roy 1982). Firstly, its backbone was the Army Medical Corps which, in any case, did not attract the cream of the profession. The army being a colonial one, it probably inducted even more mediocre personnel than were recruited for the home army. Secondly, and most imporotant, this set of second-rank professionals held, in effect, complete sway over the Indian medical and health services. And within their ambit of influence also came the native professionals, many of whom they patronised and modelled to their own prototypes to carry forward the tradition of the colonial medical services (Banerji 1975).

The Bengal, Madras and Bombay Medical Services was constituted in 1764 to cover all the surgeons employed by the East India Company (Government of India 1940:1). For a short period in 1766 and in 1796, the civil and the military branches were organized into separate services, but on each occasion they were speedily reunited. The Presidency establishments were amalgamated as the Indian Medical Service in 1896. Every member of the IMS first joined as a commissioned officer in the Army.

The Secretary of State for India in the British Government administered this cadre. After serving for periods usually varying between ten and fifteen years, they were given the option to transfer to the civil wing of the IMS. For another twenty years or so the officers occupied different posts which were left as exclusive preserves of the IMS. A few of them ended up at the very top as the Director-General of the Indian Medical Service.

Like the ICS,the members of the IMS belonged to an exclusive club, zealously guarding their turf. Again, as the case of the ICS, for considerable time the IMS remained the exclusive preserve of the British. Later, when as a result of political reforms, Indians had also to be allowed to compete for admission to the cadre, IMS lost its exclusive racial character. Indeed,in the year 1912, 8 out of the 24 new entrants to the IMS were Indians. In 1913, the number was 14 out of 35(Roy 1982). However, efforts were made to 'contain' this damage to the IMS and maintain the supremacy of the British officers. First, even as late as in 1940, some of the key posts were reserved exclusively for the British officers of the IMS(Government of India 1940:xii). The civil list contained 182 such posts out of a total of 323. Thirtyeight 'other medical posts' were 'reserved' for Indians. 103 posts were left 'open' for both Indian and British officers. Besides, in the course of their service in the IMS, the Indian officers were properly socialised and sanitised, so that they become the embodiment of 'Brown Englishmen'. Commenting on this aspect in relation to medical education in 1929, B.C. Roy (1982) made some pertinent observations:

> No professor belonging to the Medical Services has ever, to my knowledge, trained an Indian student in such a way that he may prove capable in time of occupying the chair of his teacher. It has all along been a process of safeguarding the interests of a trade union. In order to reserve the posts for the Services, it has happened that the very same professor has taught subjects like hygiene, chemistry, physiology, surgery and opthamic surgery at different periods of his service in India. We cannot conceive of a more monstrous method of imparting medical education in any country. A complaint was made by some I.M.S. Officers before the Public Services Commission that in India specialisation in any medical subject was unknown. Who is responsible for this? How can we expect anything else from those teachers who have developed only one form of

speciality namely, the speciality of possessing on overhwelming self-confidence, the speciality of rejecting all claims of the Indian practitioners to fair treatment, the especiality of belittling everything Indian.

... The Britisher complains that there is communal jealousy existing in India. Why is there so much anxiety to preserve this communalistic feeling in the profession? Why this reservsation of posts and emoluments? To an average mind it would appear that such provision can only indicate that the Britisher himself is conscious of his pride and boast that in India his attitude is one absolute fairness! I hope that you will have no hesitation in condemning this backdoor-way of securing a few more lucrative posts for the members of the Indian Medical Service.

This outburst of B.C. Roy in 1929 reflects the tensions of those days. It reflected the very understandable anger and frustration of those Indian physicians who had acquired high qualifications, but were denied access to a large number of key posts in the government simply because they did not join the IMS. Some of them, like B.C. Roy and Jeevraj Mehta, who also participated in the national movement, vowed to abolish the entire cadre of the Indian Medical Service once India was able to liquidate the British rule. After Independence, Jeevraj Mehta became the first director-general of health services and secretary to the Union Ministry of Health. The promise to abolish the IMS was kept. This, as would become apparent later on, had far reaching impact on the practice of public health in the country.

However, the nakedly racial overtones within the IMS and the active cultivation of an air of superiority over others should not obscure some very positive outcomes. This can be considered as an expected outcome from the dilectics of colonial exploitation. Domination of every aspect the medical, public health, education, training and research work, both at the Centre and in the Provinces, ensured an integrated, holistic approach to health services. The dictum, as enunciated by John Grant (Seipp 1963:3) (a non-IMS!) was: 'Good administration, it should be undertaken by one governing body for the whole community needing service and not for different sections of the community by several governing bodies'. This made it much easier to visualise health services as a part of the totality of social services

which are related to improvement of the health status of a community'. The IMS members of the Bhore Committee enthusiastically joined pioneers like John Grant (Seipp 1963) and Henry Segerist (Marti-Ibanez 1960) in asserting that the planning and development of health services be considered as a part of community development.

The reservation of an all-embracing domain for the IMS also had a very beneficial influence on the making of a health administrator. Like his counterpart in the ICS, an officer of the IMS also reached key decision making positions only after acquiring extensive experience in a number of areas: starting as a general duty officer in the Army, he went through placements in medical and public health positions in districts and the province, and going on to various positions whtin the Central Government. When he reached a key 'line' position, he carried with him rich administrative experience along with skills in medical, public health and even medical education and research. This enabled him to provide effective leadership to his organization. He was also well placed in seeking staff support laterally from his fellow IMS officers. And the discipline of the cadre also ensured loyalty and support from his subordinate officers. This 'command' over his domain, together with the power and prestige bestowed on him by the Secretary of State for India, prevented any intrusion into his domain by politicians and other administrators, including those of the ICS.

Understanding of these positive gains by the IMS is very important for analysis of the existing pattern of public health practice and for developing a perspective.

IV

SCOPE OF PUBLIC HEALTH PRACTICE

The scope of the practice of public health has changed with growth of knowledge in the medical sciences and with changes in

socio-cultural and political situation. Following the sanitary movement in Europe, the state of health and disease of a population was linked with the conditions of living. Scientists-activists like Rudolf Virchow,(Rosen 1958: 254-58) took it still a step forward by underlining the relationship of health and health services with politics. This was a part of the political plank of the liberals during the German Revolution of 1848. In that phase Virchow had considered medicine as a social science. As mentioned earlier, the British colonial rulers of India used this approach to bring about a dramatic improvement in the health status of the European serving in India.

Formulation of the specific etilogy theory of diseases, leading to the formulation of the Koch's Postulates, started another phase in the practice of public health. There was rapid expansion of othe knowledge concerning causation of some of the major scourges of that time and vaccines and sera became the major weapons for fighting them. Individuals and the specific causative agents of diseases became the main focus. A community perspective was formed by bringing together the study of a number of individuals as a collective. Interest in the theory of specific etiology of diseases generated enough knowledge in the early decades of the twentieth century to make public health practice as an area for specialisation in the medical sciences. Epidemic control, immunization, bacteriology and chemistry of water, air and food, environemtal sanitation and personal hygiene and occupational and industrial health were included within the scope of this speciality.

The modern concept of public health practice has arisen from the classic defination of public health given by CEA Winslow (1920) in 1920. Winslow further extended the scope of public health to include all organized activities in the field of health: promotion, prevention, medical care and rehabilitation. Building on Winslow's concepts, John Grant went even further and insisted that health is a collective product which requires joining of social forces in a collective effort: it is through coordination of these efforts that the aspiration expressed by the term social medicine can be realised. According to Grant, technical measures in health care services should be undertaken as an integral part of the nation-building activities as a whole. He challenged the narrow provincialism and overspecialisation and the timidity of the conventional public health practioners so strongly that in his later years he came to reject the term

'public health' and substituted for it the term 'community health care'. Following up the definition of public/community health, John Grant had extended the scope of public health practice to include such areas as medical care and hospital administration (including regionalisation of medical care), health administration, health education, health applications in the social science, health manpower development and so forth (Seipp 1962:xii-xviii).

Henry Segerist (1977: 3-7) had given a historical dimension to public health practice by relating the contemporary issues to the historical events associated with the work to activists like Rudolf Virchow, Max Von Pattenkofer, Rene Sand, John Ryle and Lord Beveridge. It may also be noted that both John Grant and Henry Segerist had played an imporotant role in the shaping of the recommendations of the Bhore Committee (Government of India 1946a: i-ii).

A still wider perspective to public health practice was provided by scholars like Rene Dubos(1952). Thomas McKeon (1976) and Walsh McDermott(1969), who drew attention to the complex ecological and biological forces which have determined the epidemiological dynamics of the states of health and disease in a community in a time dimension. Hugh Leavell (1965) followed up this concept of natural history of a disease in a community by drawing attention to distinct phases in the natural history of any disease process in an individual. By defining the flow of the natural history in terms of 'prepathogenic' and 'pathogenic' periods, he further extended the scope of preventive medicine by asserting that it covers the entire spectrum of the natural history, because, as the Latin meaning of the term 'prevent' implies, it is associated with actions that 'come before' a particular event in the natural history. Health promotion, specific protection, early diagnosis and prompt treatment, disability limitation and rehabilitation - are all considered to be preventive activities, because these activities 'come before' or forestall one of the unfavourable phases in the natural history of a disease inoan individual. Leavell thus gave a dynamic perspective to the concepts of Winslow. By projecting a health problem as different phases in ITS natural history, it is possible to identify the specific phases in individual diseases which are most vulnerable to intervention by public health practioners. Thus, in some cases (e.g., nutritional disorders) health promotion may be the major focus of intervention, while in

others (e.g., rheumatoid arthritis) the effort may be concentrated on disability prevention.

Edward McGavran (1953) had reinforced the ideas of Hugh Leavell by differentiating public health practice as practice of 'community-side medicine', as opposed to the classical clinical practice of bed-side medicine. He asserted that making of community diagnosis and solving of community health problems involved extensive use of concepts and methods of epidemiology in its widest sense. That is why he had also defined public health practice as an epidemiological approach to solving a community health problem. McGavran's ideas were helpful in defining in greater detail the widened scope of practice of public health. It meant a holistic approach to all the health problems in a community. This requires epidemiological data on the size, distribution, causative factors and time trends of all the health problems that confront a given community. Consideration of causative factors opens up issues which fall within wider social, economic and ecological fields. Besides, for making a community diagnosis, there is the fundamental requirement of making a social interpretation of epidemiological data. How does a health problem look like from the community side? In other words, how to relate the epidemiological data to data concerning the people, to determine the degree to which epidemiologically assessed dimensions of a given community health problem overlap with sociologically assessed felt needs. This approach also brings in the question of cultural perception and cultural meanings of different health problems and relating these with community health behaviour and the various institutions that are available and accessible to individual members of a community to enable them to cope with their health problems.

McGavran also worked out the process of solving a community health problem, once a community diagnosis has been made. Here, it is a question of developing an appropriate package of technology along with formulation of an appropriate delivery system which can be used to influence the strategic points within the natural history of a disease so as to have the maximum impact within a given resource constraint. This brings out the role of concepts and methods of many additional disciplines in the practice of public health. Apart from the relevance of social science disciplines, such as sociology, social or cultural anthropology and social psychology to determine the social acceptability of the package of technology and the delivery

system, it includes use of the disciplines of political science, including public administration, health economics and the various medical science disciplines which are related to the formation of an appropriate package of technology.

With these contributions practice of public health included a number of important dimensions involving use of concepts and methods of a large number of disciplines, besides developing much wider concepts and methods for use of the discipline of epidemiology. Formation of such an inter-disciplinary concept of public health practice also led to the development of new methodological aproaches like operational reasearch, systems analysis, linear programming and programme evaluation and review technique, to formulate highly complex and organized systems that can be used for solving a community health problem (Banerji 1985a: 317-22).

Thus,to sum up, development of an epidemiological approach to public health practice involves consideration of epidemiological issues at three different levels:

1. Consideration of natural histories of different community health problems in a population in a time dimension in terms of changes in the interactions among the host, the environment and the causative agents.

2. Consideration of the dimension of community health problems at a point in time as a stock. This includes consideration of the size, distribution and the causes.

3. Consideration of health problems in an individual in terms of their progress in individuals in the five phases of their natural histories to determine the strategy for intervention in the epidemiology of different health problems at given time.

Such a broadbased epidemiological approach to solving community health problems, and making it a part of the wider nation-building process, was of particular relevance at the time of Independence, when the new political leadership was poised to take action to fulfil at least some of the promises it made to the people of India. Against the background of acceptance of the framework developed by the Bhore Committee, the leadership was

virtually pushed into taking a number of major decisions which presented a particularly difficult challenge to public health practioners. The leadership committed itself to (a) building up a nationwide network of health services as a part of its wider blue-print for national reconstruction; (b) providing integrated curative, preventive, and promotive services to rural population through primary health centres (PHCs), as conceived by the Bhore Committee; (c) launching massive programmes to deal with major communicable diseases like malaria, smallpox, tuberculosis, leprosy, trachoma, filariasis and cholera; (d) meeting, both quantitatively as well as qualitatively, the manpower needs of the ambitious health programmes; (e) launching a massive programme to deal with the problem of rapid population growth by linking it with an extensive network of health services, particularly with the programmes for maternal and child health and nutrition and relating it to the wider socio-economic development progorammes, like water supply, environmental sanitation, housing, education, women's development, land reforms and decentralisation of the political and administrative system; (f) extending the network of hospital and medical care facilities as an intergral component of the health services and adopting an approach of regionalisation; (g) taking preliminary steps towards forming a national health service by offering medical and health services to organized groups such as industrial workers and government employees; and (h) promoting education, research and training in the various indigenous systems of medicine and building up networks of services as integral components of the overall health service system.

From a standpoint of comparative study of health system development, this political commitment to a wide range of development is of far reaching significance. Also, most of the tasks assigned to public health practioners after Independence was unique in nature, both in time and in space. Obviously, it was not enough merely to go on with the pattern that was developed during the colonial period, though many of the decisions made during that period did contribute to the formation of the base for specific action. Similarly, it was not possible to graft in toto the ideas and practices which had been developed in the industrialised countries, even those developed in the earlier phases of their industrialisation. Essentially, a considerable body of knowledge had to be generated endogenously. Programmes have to be formulated taking into account the special epidemiological characteristics of the health probolem, financial

and manpower resource constraints, limitations of the available technological approaches, problems of developing a delivery system and the social and cultural factors which determine the health practices and health behaviour of population under given conditions. This was the challenge posed before the public health practioners of India at the time of Independence. How far have they succeeded in fulfilling the task assigned to them? Answer to this question is to crucial relevance for understanding the development of the health service system of India.

V

MAJOR HEALTH PROGRAMMES SINCE INDEPENDENCE

A Primary Health Centre (PHC) was conceived as an institutional structure to provide integrated preventive, promotive, curative and rehabilitative services for the rural population of the country. This idea was developed as a response of the political leadership of the freedom movement to meet the rising aspirations of the masses of the people. The first batch of the PHCs was set up in 1952. Considering the nature of socio-economic relations and the power structure that emerged in India after Independence, it is not surprising that this programme of establishing a network of PHCs all over the country should have encountered so many obstacles. But perhaps it is a much more important fact that, despite these obstacles, over time there has been a steady growth and development of the network, both in quantitative as well as qualitative sense. This, incidentally, provides an instance of how the democratic aspirations of the people could impel the ruling elites to make services available to them.

Quantitatively, there has been a significant increase in the number of medical and paramedical personnel in PHCs. Qualitatively, there have been four major changes (Government of India, 1987). First, many special mass campaigns have been integrated with PHCs, both in terms of their staff as well as functions. There have also been national programmes against specific health problems which were developed as integral

components of PHCs - tuberculosis, integrated child development and blindness prevention. Second, there has been a functional integration of work of the personnel at PHCs. This has led to the development the categories of male and female multipurpose workers (MPWs). Third, a twenty-five bed hospital has been developed for every four PHCs in the country. Finally, and perhaps most importantly, a decision was taken by the Government of India in 1977 to entrust 'peoples' health in people's hands', by offering opportunities to village communities to choose from among themselves a person who would work as a Community Health Volunteer (CHV, now called Health Guide) (Government of India, 1978). The government authorities also arranged for the training of CHVs, paying them an honorarium and supplying some drugs and equipment.

The CHV Scheme was of profound social and political significance. In effect, it meant bypassing the entire medical establishment and going directly to the people to strengthen their capacity to cope with their health problems themselves and to seek and even demand support from PHCs and other referral health institutions, in case the nature of the health problems so required. Soon after came the historic Declaration of Alma Ata on Primary Health Care (World Health Organization, 1978). It called for total coverage of population with comprehensive, integrated health services, based on active participation of the people in the planning, formulation, implementation and evaluation processes. There was to be social control over the health services and, along with health services, there would be inter-sectoral action covering fields such as water supply, environmental sanitation, education, women's development and employment, to improve the health status of the people. 'Health For All by 2000 AD through Primary Health Care' (HFA/APC-2000) became a catchy and heady slogan of WHO and its member states. But soon social and political realities overtook HFA/PHC-2000. The progress was tardy; much worse, there was gross distortion of the basic postulates of HFA/PHC. The slamming down of a highly technocentric programme of universal immunization on the people of the Third World countries at the instance of affluent industrialised countries and, ironically, international oroganizations like WHO and UNICEF, provides a startling example of such distortion (Government of India, 1985; Banerji 1986b). Tragically for the Third World, even otherwise the immunization programme suffered from serious infirmities from epidemiological, operational and ecological points of view (Banerji, 1986b). That

such a programme could be forced on the peoples of the Third World gives an awe-inspiring demonstration of the power of the ruling elite and their supporters from outside, to impose their will on the masses of people.

Nevertheless, despite the many setbacks, the gains during the past decade have been substantial. There is now a dense network of health services in rural areas: one CHV/Health Guide for 1000 population; a sub-centre with a male and a female multipurpose worker for every 5000 population; a PHC for 30,000 people; a Block Health Centre for 100,000 people; and a 25-bedded hospital for 400,000 people (Government of India, 1987). No other country in the Third World with similar resource constraints can claim to have such an infrastructure of health services for its rural population (Banerji, 1985a:422).

Because of the availability of highly potent weapons to fight against communicable diseases at the time of Independence, there was considerable enthusiasm for launching specialised mass campaigns against individual scourges (Banerji, 1985a:131-36). These technocentric programmes had their own organizational structure (hence called vertical programmes), independent of the general health services. A National Malaria Eradication Programme (NMEP) was launched when spectacular results were obtained by using DDT in the National Malaria Control Programme (NMCP). However, despite massive investment of resources, the promise of NMEP rooting out malaria from the country, once and for all by the mid-sixties, could not be fulfilled and huge quantities of this country's resources are still been drained simply to keep the spread of the diseased under conttrol (Banerji, 1985a:95-106).

Before India joined the WHO sponsored programme of Global Eradication of Smallpox, India had made, on its own, two efforts to eradicate the disease (Basu et al, 1979). On both the occasions, the National Smallpox Eradication Programme did not succeed in its aim.

The Mass BCG Campaign was launched to provide protection problems in its implementation. Later, it was proved conclusively (Baily, 1980) that BCG does not provide protection to adults.

Dapsone provided a potent weapon to deal with leprosy as a community health problem and the National Leprosy Control Programme (NLCP)was launched for this purpose. Again, because of serious operational problems, it was not possible to make any significant dent in the problem. Subsequently, as a result of the initiative from the highest level of the Government of India (Gandhi, 1981) a major effort was made to thoroughly revamp the programme and add refampicin to the already existing dapsone therapy, with a view to eradicating the disease by the turn of the century (Government of India, 1982a). Once again, the results have not been encouraging (Government of India, 1987).

There have been similar disappointing results from the vertical programme launched against (Pandit, 1982) and trachoma (Government of India, 1981). As mentioned earlier, refusing to learn from past experience, the Government of India has joined some industrialised countries and UNICEF and WHO, to launch yet another technocentric 'attack' on the six communicable diseases through the Universal Programme of Immunization (Government of India, 1985b).

In sharp contrast to the other communicable diseases control programmes, India's tuberculosis programme offers a very instructivecase study of the development of an appropriate and obviously effective approach in dealing with an important national health problem within the prevailing constraints, including constraints of available resources (Banerji 1985a: 106-12).

The National Tubercolosis Institute (NTI) at Bangalore develo-ed a series of interdisciplinary operational research studies which involved participation of health administrators, epidemiologists, clinicians, microbilogists, public health nurses, laboratory scientists, social scientists, statisticians and engineers (Chakraborty 1979). This led in 1962 to the formulation of nationally applicable, socially acceptable and epidemiologically effective National Tuberculosis Programme (NTP) for India (Banerji 1971b).

The basic postulates of India's NTP were: (1) as a very large number of patients were already actively seeking treatment at various health institutions, top priority must be given in the

national programme to providing services to those who have a felt need for it, i.e., it should be a felt-need oriented programme; and (2) as those who had a felt need sought treatment at health institutions, tuberculosis services should be given as an integral part of the health services provided at different institutions.

Expectedly, heavy allocations have been made in setting up hospitals, dispensaries and other curative services in urban areas. A large number of the well-equipped hospitals have come up in the form of teaching hospitals attached to the medical colleges. There has been a general decline in the quality of the services provided by these curative institutions. This might provide one explanation for the recent trend in the privatization of medical services through opening of very expensive and sophisticated hospitals in the corporate sector.

The government has also encouraged promotion of the different indigenous systems of medicine and homeopathy by setting up a number of teaching instituions, hospitals and dispensaries in different parts of the country.

VI

HEALTH MANPOWER DEVELOPMENT

There has also been substantial achievement in developing manpower to meet the requirements of the massive health programme (Banerji, 1985a:73-91). Physicians have been produced in large numbers to serve as health administrators at different levels of the health services. Specialists have also been trained to fulfil the requirements of hospitals and other specialised institutions. Special efforts were also made to train the required number of teachers, trainers and research workers of various types. In qualitative terms, a key decision was taken soon after Independence to bring about a social orientation of medical education by upgrading the departments of preventive and social medicine in the 106 medical colleges in the country.

COMMUNITY HEALTH CELL
27/1, (First Floor) St. Marks Road,
Bangalore - 560 001.

768

Urgent steps were also taken to meet the massive manpower needs in nursing. This meant education and training of nurse educators, nurses for hospitals and a vast army of auxiliary nursing personnel, especially auxiliary nurse midwives (ANMs), who were later designated as female multipurpose workers, and their supervisors. The corresponding male multipurpose workers were also provided education and training. The national programmes for malaria, the family planning programme and the vast PHC complexes, each required education and training of more than a hundred thousand paramedical workers. There has been, in addition, education and training of over four hundred thousand Community Health Volunteers/Health Guides. The country can justly be proud of these achievements in developing its health manpower.

VII

FAMILY PLANNING

Preoccupation with curative services and with the very expensive vertical programmes led to the neglect of growth and development of general health services in rural areas. The pushing of the family planning programme during the past quarter of a century has turned out to be an even greater disaster for health service development in rural areas. Today the family planning programme stands out as the darkest and the largest blot on the landscape (Banerji, 1985a:247-49). a The root cause lies in the basic postulation of the programme. Instead of relating the problem of population to the prevalence of widespread poverty and the unjust social order which generates such poverty, it was postulated that it is the population grwoth which is responsible for poverty. It was presumed, rather simplistically, that the population growth has eaten away the fruits of development. As if the failure of the ruling elites to comply with the Directive Principles of the Constitution (for example, universal primary education by 1960, land reforms and employment) was due to population growth!

This 'victim blaming' philosophy of the exponents of the

family planning programme triggered off a chain reaction (Bose, 1985). People became the victims of targets of their own government for sterilization. They were subjected to a blast of propaganda, prophesying a Malthusian doom unless they submitted themselves to sterilization. Efforts were made to entice people to accept family planning by offering them monetary incentivies. Health workers and even other government functionaries working in rural areas were threatened with dire consequences if they failed to attain their targets (Bose, 1986). In turn, the health workers and others started to pressurise people to fulfil their targets. Thus, the family planning drive created a sense of terror among health workers and government functionaries. It became a menace to the people. It very adversely affected the functioning of rural health services. It also gave rise to a number of malpractices, such as sterilization of old people or people with high parity, false reporting and terrorisation of the poor and vulnerable sections of the population by government functionaries.

The tragedy is that, despite incurring a very heavy expenditure, despite the high price paid in terms of disruption of health services and despite adoption of means which were patently immoral and often illegal, the family planning programme failed to yield the desired results (Bose, 1987). It is therefore not surprising that sometimes there was no correlation between percentage of couples protected and the decline in the birth rates. The zealots of family planning also overlooked some important facts about population control - that a decline in marital fertility rate is also brought about by people practising birth control on their own and that rise in the age at marriage and reduction in the proportion of the women in the reproductive age group also significantly affect birth rates. It was not noted that along with the family planning programme, these factors have also played a major role in bringing about the spectacular fall in the birth rates observed in Kerala. Perhaps the best way will be to quote at some length the

VIII

ASSESSMENT OF THE HEALTH PROGRAMMES

Perhaps the best way of assessment will be to quote at some

length the observations made in the Statement of the National Health Policy of the Government of India (1982b):

> Inspite of such impressive progress the demographic and health picture of the country still constitutes a cause for serious and urgent concern. The high rate of population growth continued to have an adverse effect on the health of our people and the quality of their lives. The mortality rates for women and children are still distressingly high; almost one third of the total deaths occur among children below the age of 5 years; infant mortality is around 129 per thousand live births. Efforts at raising the nutritional levels of our people have still to bear fruit oand the extent and severity of malnutrition continues to be exceptionally high. Communicable and non-communicable diseases have still to be brought under effective control oand eradicated. Blindness, leprosy and T.B. continue to have a high incidence. Only 31 per cent of the rural population has access to potable water supply and 5 per cent enjoys basic sanitation.
>
> High incidence of diarrhoeal diseases and other preventable and infectious diseases, specially amongst infants and children, lack of safe drinking water and poor environmental sanitation, poverty and ignorance are among the major contributory causes of the high incidence of disease and mortality.

This is followd by an analysis of the possible causes of this obviously unsatisfactory state of affairs:

> The existing situation has been largely engendered by the almost wholesale adoption of health manpower development policies and establishment of curative centres based on the western models, which are inappropriate and irrelevant to the real needs of our people and the socio-economic conditions obtaining in the country. The hospital-based, disease and cure-oriented approach towards the establishment of medical services has provided benefits to the upper crusts of society, especially those residing in the urban areas. The proliferation of this approach has been at the

cost of providing comprehensive primary health care services to the entire population, whether residing in the urban or the rural areas. Furthermore, the continued high emphasis on the curative approach has led to the neglect of the preventive, promotive, public health and rehabilitative aspects of health care. The existing approach, instead of improving awareness and building up self-reliance, has tended to enhance dependency and weaken the community's capacity to cope with its problems. The prevailing policy in regard to the education and training of medical and health personnel, at various levels, has resulted in the development of a cultural gap between the people and the personnel providing care. The various health programmes have, by and large, failed to involve individuals and families in establishing a self-reliant community. Also, over the years, the planning process has become largely oblivious of the fact that the ultimate goal of achieving a satisfactory health status for all our people cannot be secured without involving the community in the identification of their health needs and priorities as well as in the implementation and management of the various health and related programmes.

The Statement on National Health Policy (Government of India, 1982b) asserts that its contours have been evolved within a fully integrated planning framework which seeks to provide universal comprehensive primary health care services relevant to the actual needs and priorities of the community at a cost which the people can afford, ensuring that the planning and implementation of various health progorammes is through the organized involvement and the participation of the community, adequately utilising the services being rendered by private voluntary organizations in the health sector.

To put an end to what it calls the existing all-round unsatisfactory situation, the Statement underlines the urgent necessity of restructuring the health services around the following broad approaches:

1. Provision of a well-dispersed network of primary healthcare services with the organized support of volunteers,

auxiliaries, paramedics and adequately trained multipurpose workers.

2. Large-scale transfer of knowledge, simple skills and technologies to Health Volunteers, selected by the communities and enjoying their confidence.

3. Positive efforts to build up individual self-reliance and effective community participation.

4. Back-up support to primary health care through a well worked out referral system.

5. A nation-wide network of sanitary-cum-epidemiological stations to tackle the entire range of poor health conditons.

6. Full utilisation of untapped resources through organized logistical, financial and technical support to voluntary agencies active in the health field.

7. Planned establishment of centres equipped to provide specialist treatment when necessary.

8. Special efforts to offer mental health and medical care and physical and social rehabilitation to the disabled.

9. First priority to be accorded to people living in tribal, hill and backward areas oand to populations affected by endemic diseases.

In essence, the National Health Policy embodied a commitment of the ruling elites of India to bring about further

democratization of the health service. This implied subordination of medical technology to the needs of the people. It was thus yet another gain for the masses of the people. However, not unexpectedly, during the past five years there has been little progess in the implementation of the declared policies: another instance of the 'soft state' of Myrdal (1968:20). Infact, from the standpoint of the interests of the masses, these five years have brought yet another major setback - indeed a major step backward. This is in the form of India's acceptance of a technocentric programme of mass immunization which is imposed on the people from above. Such a programme is the very antithesis of the Alma Ata Declaration and the National Health Policy. Worse still, as in the case of the National Malaria Eradication Programme and the family planning programme, imposition of this programme and exertion of administrative pressure on individual health workers for attaining the assigned targets adversely affects the performance of other rural health programmes, for example, maternal and child health services. The masses have to struggle still harder to force the ruling elites to rectify these defects and to ensure implementation of the National Health Policy.

IX

ADMINISTRATION OF THE HEALTH AND FAMILY PLANNING SERVICES

The causes of the very serious failures in the health and family planning services are related to the social and political forces which have shaped some of the key decisions. Essentially, study of the causes amounts to study of the political economy of health and health services in the country (Banerji 1984). It will therefore need major social and political action to rectify the situation. However, as the main purpose of this presentation is to describe and analyse the trends in public health practice in India, here the major focus will be on the immediate factors which are responsible for this sharp decline in the practice of public health. These factors are highly complex, closely interacting with one another. The discussion below will be confined mostly to five categories of these factors:

1. Consequences of abolition of the all-India cadre of othe IMS and not replacing it with an alternative one.

2. Steep fall in the quality of education, training and research in public health and the low position assigned to public health practioners in the prestige hierarchy of health professionals.

3. With the virtual disappearance of public health as a speciality, decision makers had filled up key positions in health administration with medical personnel who had neither any training, nor experience, nor interest in that field. One can easily single out instances of anatomists, physiologisits, pharmacologisits, biochemists, pathologists, microbiologists, laboratory scientists, orthopedicians, surgeons, physicians and obstetricians and gynoecologists, who have been given key positions requiring high levels of competence in health administration.

4. The Administrative Reforms Commission of the Government of India (1969) had included the ministiries of health and family welfare at the Centre and the States among the ones where in due course the top positions are occupied by health administrators. That did not occur. Instead, during the past four decades these minisitries have become even more dominated by generalist administrators.

5. The political leaders ought to be squarely held responsible for the present unsatisfactory state of affair. in public health practice. They have been heading health ministires at the Centre and in the Provinces following the reforms of 1919 and 1935. They have been actively involved in the key decisions in personnel management in health services which have led to the sorry state of public health practice in the country. There has also been a steady decline in the quality of the overall political leadership of health minisitries. The legislative bodies and various political parties have also to share some of the responsibility, because they were not active enough in drawing attention to the poor levels of political leadership of ministires of health.

Reference has already been made to the deep seated resentment among some eminent nationalist-minded physicians against the practice of giving the IMS monopolistic positions in all aspects of the health services in the country during the colonial period - in medical education, medical research and in health administration. While both the ICS and IMS came under strong criticism from the leadership of the national movement because of their association with the colonial rulers (Roy 1982; National Planning Committee 1948), it so happened that the IMS did not survive Independence. While the Indian Civil Service was succeeded by the equally exclusive Indian Administrative Service (IAS), there was no corresponding substitute for the IMS and it was phased out. Belated efforts were made to rectify that situation by proposing an all-India cadre to be called the Indian Medical and Health Services, but it could not take shape as it failed to receive the concurrence of all the states of the Union. Failing to set up an all-India cadre, the Government of India brought together its own officers from the fields of medical education, medical care and public health to form a new cadre of its own, called the Central Health Service (CHS).

While, on the face of it, creation of a single cadre appears to be a sound practice in health administration, it was not realised adequately at that time that the creation of a single cadre of personnel in an organisation which lacks the vital base of executive positions in the health services in the states would create serious anomalies. Thus, unlike the situation prevailing during the pre-independence days, the Directorate-General of Health Services (DGHS) could not get officers who had grown in the service, acquiring experience through managing community health services and developing epidemiological perspectives. This anomaly in the organisational structure also led to a disproportionately large representation of physicians from teaching institutions at the higher levels of the cadre. As a result, frequently, seniority in the CHS cadre has enabled persons to occupy key positions within the DGHS for which they had virtually no experience. Thus, at a time when the country needed managerial physicians who would have much greater competence than those who belonged to the IMS, those occupying key positions in the DGHS often fell very far short of what was required of them. The vacuum created by the phasing out of the IMS and the consequent decline in the competence, power and prestige of the CHS officers offerred opportunities to generalist IAS officers further to extend their influence and control over

decisions which involved consideration of technical issues. The IAS officers were obviously not competent in performing these roles.

The phasing out of the IMS also had a major impact on the administration of health services in the states. This had led to considerable erosion in the competence of health administrators at a time when they were required to show much greater initiative, enterprise and administrative vision in the face of the rising expectations and aspirations of the people. In the first place, health being essentially a state subject, the admibnistrators were expected to develop their own pattern of health services to suit the conditions prevailing in individual states. In the absence of such action, the state authorities had to fall back on the 'standard pattern' handed down to them by the not so competent health administrators of the Union (Central) Government.

Second, development of health services in rural areas through the national programmes, primary health centres, dispensaries and taluk and district level hospitals called for fundamental changes in the structure of the organisation and in administrative practices. Third, assigning the overriding priority to the family planning programme posed yet another type of administrative challenge. Finally, there was also the administrative challenge involved in the expansion and strengthening of the institutions and health services (like medical colleges, their attatched hospitals and other large urban hospitals) which had already existed before Independence.

At the time of Independence, even before the decision to phase out the IMS came to be felt, public health practioners faced some other special problems. One was the withdrawal of a substantial number of British members of the IMS. This created a sudden vacuum in their ranks. At the same time there was a very large expansion of the health services to meet the rising aspirations of the people of the country. Over and above, members of the IMS, who had grown up in the cadre in the militaristic traditions set during the colonial period, were called upon to face qualitatively different types of challenges. Obviously, programmes which required mobilisation of large masses of rural population was not a very palatable proposition to them.

Rural population raised in their minds the spectre of difficult access, dust and dirt and superstitious, ignorant and illiterate people. Therefore, when they were impelled to do some preventive work in rural areas, characteristically, they chose to launch military style campaigns against some specific health problems - the so-called vertical programmes.

Also, because of strict seniority rules of the IMS, when the health services expanded rapidly, the administration had to fill up many key posts from amongst the relatively small numbers of the officers, who, even from the colonial standards, were not considered to be bright. Such a massive domination of the organization by personnel, who had been trained in the colonial tradition and whose claim to a number of vital posts was based merely on their being senior in a depleted cadre, led to a virtual glorification of mediocrity, with all its consequences. Worse still, such a setting was inimical to the growth and development of the younger generation of health workers. These young workers had often to pay heavy penalties, if they happened to show, on their own, initiative, enterprise and imagination in their work. Conformation usually earned good rewards. This ensured perpetuation of mediocrity within the organization. This is obviously a major explanation for the serious flaws in the conceptualisation and implementation of many important health programmes observed so often in earlier paragraphs (Banerji 1975).

Because of their being inadequate for the jobs, many health administrators went out of the way to seek help from experts from abroad. A large number of such experts were invited to play a dominant role in many aspects of the health service system of the country.

It may, however, be noted that notwithstanding its strong hangover from the colonial period, its military style approach to community health problems and the considerable dilution of the cadre at the time of Independence, the IMS still managed to provide strong leadership at the highest level of health services - at the level of the director-general of health services (DGHS) at the Centre and that of directors of health services in the provinces/states during the first two decades. Col. K.C.K.E.

Raja, Col. C.K. Lakshmanan, Col. V. Srinivasan, Col. Jaswant Singh were among the influencial directors-general of health services. Each one of them had strong background in public health, besides having rich experience in health administration at the district, state and Central levels and, often also in medical education and in research. Significantly, two of them had served as the Director of the All India Institute of Hygiene and Public Health (AIIHPH), before becoming the DG; Col. N. Jungalwala was another director of AIIHPH who played a crucial role in setting up the National Institute of Health Administration and Education and who had become the Additional Director-General of Health Services. The AIIHPH thus served as a nursery for the formation of a DG. Because of this association with AIIHPH, they could carry forward the ideas of John Grant and of the Bhore Committee when they reached the highest post in the health administration of the country. Another IMS officer, Col. Barkat Narain was involved in the critical task of setting up a network of primary health centres as a part of the nationwide movement of community development. Col. C. Mani was instrumental in laying a sound foundation for the South-East Asian Regional Office of the WHO.

From hindsight, this period looks much brighter because the situation deteriorated rapidly when the IMS was finally phased out and their positions were taken by personnel who were grossly unprepared or even ill-prepared for the crucial jobs within the health administration.

With the Safdarjung Hospital and some medical colleges coming into the picture in producing the new breed of the DGs, the AIIHPH was allowed to fade away. The ideas of John Grant and those enunciated in the Bhore Committee lost their meaning and serious compromises were made with some of the vital principles of public health practice. This led to gross neglect of such vital areas as use of epidemiological concepts and principles in programme formulation and implementation and in the measurement of their impact, development of health services as an integrated system and management of complex health programmes which covered large populations in different parts of the country. Implementation of the National Malaria Eradication Programme (NMEP) and the succeeding Modified Plan of Operation is an example. The much heralded report of the Working Group for the

Eradication of Leprosy (Government of India 1968a) set up in at the instance of the then Prime Minister, is another example. It was headed by the Chairman of the Scientific Advisory Committee of the Government of India, who is a radiation biologist and it also included the then Director-General of the Indian Council of Medical Research, who is a pathologist. Some programme officers and other specialists in leprosy were also members of the Group. So casual they were about the understanding of even the pathogenesis and the course of the disease that they claimed that India should 'eradicate' leprosy by the turn of the century through the use of such technocentric weapons as vaccine development with use of 'immunomodules' and resorting to multi-drug therapy. They did not even consider the principle of integration of health services, so strongly advocated by scholars like John Grant, Hugh Leavell (1968) and N. Jungalwala (Government of India 1968b) and by the Sokhey Committee, Bhore committee and the Alma-Ata Conference on Primary Health Care, and emphasized, without producing a shred of evidence, 'the essentiality of verticality'.

There is a similar sad account of erosion of some of the basic principles of health administration in the case of the family planning programme. First, it was the vivisection of the directorate-general of health services by tearing off from it family planning, maternal and child health and a part of public health nursing and passing it on to a commissioner in a separate department of family planning directly under a generalist secretary. That was in 1966. The political decision was to make the retired Lieutenant General S.L. Bhatia as the first commissioner. He had soon to be succeeded by Col. Deepak Bhatia of the IMS, who was earlier the Director of Health Services of Punjab. However, retirement of Col. Bhatia started the usual trend. An obstetrician and gynaecologist (again from the Safdarjung Hospital!) succeeded Col. Bhatia. She was succeeded by a surgeon from Willingdon Hospital, New Delhi and then there was a pathologist, then a physiologist and then a pharmacologist from medical colleges! That was the time when the generalist administrators struck again. It was decided to make a joint secretary also responsible for the technical aspects and designate her as ' joint-secretary-commissioner family planning'. Later, it was tagged to an additional secretary. More recently, the position of the commissioner family planning has moved with the promotion of an aditional secretary to a special secretary.

An effort was made to revive the AIIHPH by bringing in an experienced professor of preventive and social medicine, who had later became the joint director of health services of Maharashtra, as its head. But the experiment did not succeed. Earlier, a determined bid was made by Col. N. Jungalwala along with Hugh Leavell and Edward McGavran to build up a critical mass of scholars at the National Institute of Health Administration and Education (1971) to provide the badly needed leadership in the field of health administration. It was a most laudable venture, but, once again, NIHAE fell short in performing the task assigned to it. It started to decline under the stewardship of the succeeding directors and the decline became a precipitous fall when NIHAE was merged with the National Family Planning Institute to form the National Institute of Health and Family Welfare (NIHFW). The first director of NIHFW was a microbiologist. He was succeeded by a pharmacologist. Currently, the head is a reproductive biologist. A National Institute of Communicable Diseases was set up with the ambitious expectation that it could play the leadership role in the field of communicable diseases, as was done by the Centre for Disease Control in Atlanta, Georgia USA (Pandit 1982). These expectations were also belied. The Indian Council of Medical Research also soon lost its rich tradition of initiating epidemiological and other public health studies concerning key national progorammes like tuberculosis and filariasis.

The situation was equally grave in the states after the IMS was phased out. There was a sharp decline in the leadership for providing effective, integrated health services to the people. Critical principles of public health practice were allowed to be violated with impunity. One consequence was the break up of the directorates of health services into three separate directorates - medical, public health and medical education, as if there is no link among them. The State of Tamil Nadu has carried on this disruption to the level of having six (or even more?) directorates (Rao 1982). One malignant outcome of this break up has been the appearance of special secretaries of the IAS cadre in some states who have taken over the responsibilities for actually running the entire family planning and maternal and child ohealth services in the states!

The Bhopal Tragedy also dramatically demonstrated how serious has been the breakdown of public health services in the country. Even if such important factors as the considerations which led to the location of the plant so near thickly populated areas of the city, criminal negligence in implementation of safety measures and drawing up of contingency plans to minimise damage to people in the event of an accident, are excluded for analysis, the Bhopal Tragedy was essentially a public health problem: many tonnes of highly toxic chemicals were literally sprayed over an area containing hundreds of thousands of human obeings. It goes to the 'credit' of the scientists of the Indian Council of Medical Research that they managed to convert this public health problem into problems for laboratory and clinical research. There was a lack of information on such elementary epidemiological aspects as the exact number of the dead, their distribution according to age, sex, place of residence, quality of housing, socio-economic status and degree of exposure, the composition of the 'gas', the direction of its flow, its concentration and the rate of its descent in different areas. But, almost overnight, a huge empire of laboratory and clinical research came into existence with more than generous support the Government of India (Banerji 1985b).

Similarly, public health measures ought to have been adopted to ensure that Kala=Azar does not stage a comeback and that Japanese Encephalitis is not allowed to spread into the country. And, when they did start to occur, these diseases ought to have been subjected to careful epidemiological surveillance and analysis and an eloborate strategy drawn up eradicate them. The actions taken thus far have fallen far short of these requirements. They were half-hearted, patchy and of poor quality. The approach is so defective that it is not even possible to get a fair estimate of incidence of these diseases. Under such conditions it is not surprising to find the authorities taking panicky actions in the form of launching haphazard immunization drives or insecticide spraying among limited populations when there is outcry of Japanese encephalitis, kala=azar or meningococcal meningitis.

Thus, during the post-IMS period, even within the realm of medical specialists, two mutually reinfercing factors were at work. Gradually these became so powerful that they struck a

crippling blow to the vital public health organizations and institutes of the country. The very failure of the public health practioners to rise upto the challenge tempted persons from other specialities to grab certain coveted positions, thus further accentuating the crisis. Therefore, the most critical step for improving the situation would be to develop the new concepts in the education, training, practice and research in public health so that public health practioners develop competence to cope with the very complex health problems of the country.

Apart from the blunder of abolishing the IMS and not replacing it with an alternative all-India service, the leadership of independent India consciously retained the colonial legacy of supremacy of the generalist administrators (IAS) in the ministry of health, despite a strong plea to the contrary by the Administrative Reforms Commission (Government of India 1969). At the Centre, the secretariat is responsible for the key functions of policy formulation, planning, personnel and financial administration. As it represents the view of the Union Government, the secretariat also deals with its counterparts in the state governments, various health institutions affiliated to the ministry and international agencies and foreign governments and institutions.

There are two departments in the Union Ministry of Health and Family Welfare, the Department of Health and the Department of Family Welfare (Government of India 1984:Ann.II). The Department of Family Planning is distinguished by the fact that, unlike the Department of Health, it does not have a separate office of specialist officers trained in various fields of family welfare. The specialists are placed under the direct administrative control of the additional (now special) secretary, who is also designated as the commissioner of family welfare. In the hierarchy, top specialists dealing with such areas as nursing, maternal and child health services, family planning services, rural health services, programme appraisal, area projects, sale of condoms and evaluation are placed under joint secretaries.

The organisation of the Union Ministry of Health and Family Welfare thus has four characteristic features:

1. The IAS officers, who occupy positions of leadership, do not themselves have teahnical expertise in various aspects of the health services.

2. Their placement in the ministry is episodic and this makes it difficult to hold them accountable for their decisions.

3. The officers in the ministry wield considerable power as they deal with such key areas as personnel and financial management and policy formulation and planning.

4. Even in hierarchical terms, the director-general of health services and his officer in the 'attached office' of the directorate-general of health services are placed in positions which are lower than their counterparts in the ministry. The situation is even more unfavourable to the technical personnel in the Department of Family Welfare as they are located within the department itself and the top technical officers have three tiers of generalist administrators above them - a joint secretary, the additional special secretary-cum-commissioner family welfare and the secretary, ministry of health and familuy welfare (Banerji 1985a:46).

It may be recalled, once again, that, right from the days of the freedom struggle, there has been a strong demand that a single highly qualified health professional should head the entire health services organisation at each level, both in the Union and State Government (Seipp 1963). What was aimed at was a 'unified line of command'. It is the Union Government which first violated this laudable principle of integration of health services when a separate Department of Family Planning (Welfare) came into being in 1965 in the face of mounting pressure to control the rapid growth of population (Programme Evaluation Organization, 1970).

Precipitous decline in the quality of specialists in public health/health administration and the conscious political decisions to fill in key positions in the health administration with CHS physicians with clinical, para-clinical and basic science background created fertile grounds for further expansion

of influence of generalist administrators in influencing or even shaping decision in purely technical fields. It may be recalled that there was not a single ICS official in the Bhore Committee, not even in the secretariat (Government of India 1946a: i-i). The officials were all from the IMS. The 1963 Committee on Basic Health Workers was chaired by the then director-general of health services, an IMS officer (Government of India 1963). But the ICS secretary took over the chairmanship of the committee which in 1968 recommended separation of family planning work from the purview of the basic health workers (Government of India 1968a); he was also the chairman of the committee which suggested major changes in the family planning programme to enable large-scale use of the IUD (Government of India 1966). The pattern got set and generalist administrators almost routinely started heading key committees on such highly technical issues as the National Malaria Eradication Programme (Government of India 1970) and formulation of the Multipurpose Workers' Scheme (Government of India 1973). When approached by international agencies and other foreign organization to nominate participants for discussions on technical aspects, they sometimes nominated IAS officials. Some of them even obtained jobs in organizations like WHO and United Nations Fund For Population Activities (UNIFPA).

Appointment of IAS officials to directly administer family planning and maternal and child health services in some states is a more serious manifestation of this malady. Formulation and implementation of the Community Health Workers' Scheme (Banerji 1985a: 273-79), the Area Projects (Banerji 1985a: 205-07) and the Universal Programme of Immunization (Government of India 1985) are other manifestations of this malady. These are being briefly presented below.

As pointed out earlier, launching of the Community Health Workers' Scheme to entrust 'people's' health in people's hands' posed a particularly challenging task in public health practice. However, a generalist administrator headed the team which designed the scheme and provided the leadership to its implementation. It is, therefore, not surprising that the programme fell so short of the expectations in coming to grips with the public health issues (Banerji 1985a: 277-79).

Generalist administrators played an even more dominant role in launching what came to be known as Indian Population Programmes (IPP) or Area Projects. The US $29 million IPP-I (1973;1978) was launched in 1971 with what has now be seen as a simplistic approach to child survival as a means to promoting family planning. Later, once again, generalist administrators drew up what they called a 'Model Plan' to launch the IPP-II or Area Projects (Government of India 1982c). The Area Projects cover sixty-five districts and cost over two hundred and fifty crores (two and a half billion) rupees (Government of India 1984). This too proved a dismal failure because from the standpoint of health administration, these were based highly questionable assumptions (Bose 1985; Banerji 1985a: 205-07, Banerji 1985c).

The planning and programming of the Universal Programme of Immunization is an even more astounding manifestation of lack of sensitivity to some of the basic principles of public health among the decision makers. The 'task force'(Government of India 1985) set up for this purpose was headed by the commissioner of family planning, an IAS officer. It drew up a blueprint for a nationwide programme of immuniztion without having even the most elementary epidemiological data concerning the relevant communicable diseases. It paid little attention to such vital questions as the effecacies of the vaccines, preservation of their potencies through maintenance of cold chains, implications of building up a nation-wide system of delivery of the vaccines, the impact of the programme on other activities of the health institutions and the relevance of impact the programme might have under the prevailing conditions of human ecology in the country (Banerji 1985b). The fact that the Government of India (1985) agreed to invest as much as three hundred crores of rupees gives an estimate of the staggering decline in the quality of practice of public health in country.

The political leadership must take most of the blame for such a sorry state of public health practice in the country. They did not act effectively enough to stop the slide in the fields of education, practice and research in public health. They actively approved placement of obviously unqualified physicians in key positions in the health services. Following the same trend of gross neglect of the interests of the people of

this country, they allowed the generalist administrators to make technical decisions which required high level of competence in public health.

The ministers incharge of ministries of health and family welfare at the Centre and in the states who are responsible to the Parliament or state legislature, have been actively associated with all the major decisions and acts of omission and commission which have led to the present state of the health and family welfare services in India. Many of them are cabinet decisions, thus they had the approval of the entire council of ministers of the government. Appointments to key positions are approved by the cabinet sub-committee on appointments, which is presided over by the Prime Minister or the respective state chief minister. The Planning Commission and the Central Council of Health and Family Welfare are also associated with many of the decisions.

Thus, the changes in public health practices in India are, in fact, the reflections of the degree of political commitment, which, in turn, is based on the socio-cultural conditions at a given time. However, within a given political and socio-cultural situation, the personality of a minister of health and family welfare has had some influence. When, for instance, Dr. B.C. Roy held the portfolio of health in West Bengal, he brought about major improvements in the health services - for example, the director of health services was also the secretary to the department of health; the cadre of the state health service was reorganized and strengthened considerably; at the district level, health services were integrated, with the chief medical officer being made responsible for all the health activities in the district. Interestingly, it is not possible to single out any other minister like Dr. B.C. Roy, neither at the Centre nor inothe other states, who could influence health services development through the sheer weight of his personality and prestige - not even Sheikh Mohammad Abdulla, who had been the health minister of Jammu and Kashmir.

Most of the health ministers played a passive role. Often they did not even care to learn about the major issues of health service development in the country or inotheir respective state.

It is this passivity at the level of political leadership which has allowed many of the personnel belonging to the Central Health Service and the Indian Administrative Service to bring about so many distortions in the health service system of the country. However, there have been occasions when ministers were forced into active action by compulsions of the political situation. Ironically, it is Shri Raj Narain, who became the Union Health Minister in the wake of the Emergency, who can be considered among the most activist among health ministers, when they are evaluated in terms of the decisions taken. The Community Health Workers' Scheme was launched at his initiative; he had also been instrumental in building a wider base for the family planning programme; and a draft national health policy in line with the ideas of Sokhey Committee and the Bhore Committee was formulated when he was the minister. These decisions were so politically compelling that, despite their personal aversion for Shri Raj Narain and the Janata Government, none of the Union Health Ministers who followed him in the wake of the overthrow of that government in 1979, dated to openly reverse the decisions taken by him. At the World Population Conference at Bucharest, Dr. Karan Singh declared that 'Development is the best contraceptive!' He also brought out a book entitled: Population and Poverty. However, political compulsions forced him to go back on the earlier lofty pronouncements and he was made to advocate the infamous population policy of 1976 and preside over the ministry which let loose a reign of teror on the people of the country in the form of the mass sterilization drive of the Emergency days.

Dr. Sushila Nayar and Dr. S. Chandrasekhar were also active Union health ministers in a negative sense, because they became the vehicle of the political forces which gave much stronger Malthusian overtones to the family planning progroamme, which caused serious damage to public health practice in the country. The first Union health minister, Rajkumari Amrit Kaur, embodied othe aspirations of the national movement - primary health centres, upgraded departments of preventive and social medicine, abolition of the IMS cadre and making Dr. Jeevraj Mehta the first director-general of health services-cum-secretary to the Union ministry of health. Setting up of the All-India Institute of Medical Sciences, launching of many of the vertical programmes, including the control and eradication programmes against malaria and abilition of the licenciate level of medical education as it

did not conform to 'international standards', were some other decisions of her time of stewardship of the ministry. She took decisions for which the country had to pay dearly in the later years. She failed to provide the criticaly needed leadership to lay a sound foundation for health service development in independent Insia. Performance of most of her successors was much worse. Unfortunately, it is also not possible to identify even one state health minister who had shown any degree of imagination oand initiative which is soo vitally needed for health service development in a country like India.

X

EMERGENCE OF A NEW PUBLIC HEALTH

The process of health service development in India has thrown up a number of ideas which have imparted a new dynamism to the discipline of public/community health. Many of these ideas had to be generated de novo to meet special contingencies existing in a Third World country like India. Many ideas have been developed to strengthen aspects of the knowledge of public health which has evolved in Western industrialised countries. There are, however, many ideas developed in Western countries which are simply not relevant because the conditions prevailing in Third World countries are basically different. There are some other ideas in the conventional knowledge of public health which have become obsolete because of generation of new data and new lines of thinking. Taking account of these considerations, a stage seem to have been reached to project a basically different body of knowledge in public health. To differentiate it from the conventional knowledge developed in Western countries, this may be termed as New Public Health. Some of the major elements of the New Public Health which have been identified in the foregoing account of health services development in India are being recapitulated below:

1. John Grant (Seipp 1963:81) laid the foundation of New Public Health by asserting that health services must be organized as an integrated whole, that it should be accessible 'to all persons regardless of their income or source of financial support, regardless of their geographical location and regardless of their race or creed or political beliefs' and that an individual village with an average of one thousand inhabitants ought to support a community health worker

chosen from among themselves who 'can assume responsibility for all phases of community reconstruction, including health'. These ideas were reiterated, reinforced and extended by the reports of the Sokhey Committee and the Bhore Committee and in the Alma Ata Declaration of 1978 and in the National Health Policy of 1982. This opened an approach which is qualitatively different from what had been adopted in Western countries.

2. New ideas were generated to give an operational form to the new principles enunciated by John Grant and others. Concepts and methods were developed to define the dimensions of practising 'community side' medicine, as opposed to 'bedside' practice of clinical medicine. This needed formulation of epidemiologival approaches for dealing with community health problems. Along with use of epidemiological tools to understand community health problems in terms of dynamics of interaction among the host, causative agents and the environment, it also required the use of concepts and methods of different social science disciplines (e.g., sociology, cultural anthropology, social psychology, demography, public administration and political science, economics and history) to provide social dimensions to the epidemiological data. These data are then used, along with (a) data from biomedical sciences and technology; (b) data on organization and management approaches to develop the delivery system; and (c) data on social organization and motivation and behaviour of individuals in the community, to work out a strategy of intervention in the different phases of the natural histories of the different health problems which would ensure effective use of the available resources in terms of funds, personnel, materials and technology. This approach is obviously critical to practice of New Public Health. Optimisation of output of such highly complicated systems requires adaptation and use of new research methods, such as operational research, systems analysis and linear programming. These tools have been actually used in the formulation and implementation of the National Tuberculosis Programme of India (Banerji 1971b). Such a researfh approach, where attempts are made to optimise highly complex health service systems, form a part of what has come to known as health systems research (World Health Organization 1985).

3. Practioners of New Public Health will be required to have education and training which is much wider and deeper than what is traditionally imparted in public health institutions. They will be required to have both managerial as well as epidemiological competence to formulate and implement health programmes. For this reason this new type of health administrator is called a Managerial Physician. They ought to also have considerable social and political skills for implementing health services. Programmes for education and training of such personnel form another important content of New Public Health.

4. The Bhore Committee had called for a basic reorientation of medical education in India to produce 'Social Physicians'(Government of India 1946b:18), who could have the competence needed to implement many of its ambitious recommendations. The task of producing social physicians also serves as a pointer to much wider issues of development of health manpower (HMD) for the practice of New Public Health. Issues in HMD must emerge from wider issues of health systems development (HSD). Research in HSD must therefore form the basis of HMD (often called Health Systems Research for Manpower Development - HSMD)]Fulop and Roemer 1982[. The approach is to consider the manpower requirement of the system, with the start being made at the community level, because it must be based on community needs and its perceptions and meaning of health problems and that the people themselves form an important component of the needed manpower - their instrinsic capacity to cope with many of their own health problems. Following them is the question of the available resources in terms of practioners of traditional systems of medicine, traditional birth attendents and the community health workers. The multipurpose workers, backed by the entire echelon of line supervisors, ending with the top managerial physician, i.e., the director of health services, to support the efforts at the community level, form another important element of manpower structure. The line organization requires suport from staff personnel consisting of various medical specialists and other professionals like the nurses, engineers and social scientists. The manpower nebded for

the institutions for education, training and research also form another significant component for health manpower planning and development.

5. Health services are only one of the means for improving health status of a community. Health status is an outcome of complex intersectoral activities. Indeed, health status and the pattern of health services of a community is rooted in its ecological setting and in its overall way of life - that is, its culture.

Thus, New Public Health embodies knowledge generated on the basis of according primacy to the people. Starting from the people, rather than from technology, has formed the foundations for development of concepts and methods of New Public Health. This approach situates the health of a population in its social, economical and ecological setting. Actions in social and economic fields, in their turn, are considered as parts of a political process. Again, a political process is an articulation of the socio-cultural aspirations of the people, which emerge from the existing modes of production and production relations. Going further still, socio-cultural aspirations have their roots in the history and in the dynamics of human ecology (Banerji 1986a: 148-50). Correspondingly, this approach also underlines the fact that the very social and political forces, which determine the health status of a population, also determine the growth and development of its health services. Thus, developments both in health and a health service system should be basically considered as components of socio-cultural and political processes (Banerji 1986a: 417-27). In effect, it leads to the rediscovery of what Rudolf Virchow had advocated in the middle of the nineteenth century - that medicine is essentially a social science (Rosen 1958:86).

In terms of the specific task of formulation of a health service system, these social and political parameters of New Public Health impart a sociological and epidemiological perspective to the managerial and technological processes in public health practice. In other words, health problems are considered not only in terms of the factors determining the dynamics of their prevalence and incidence in the entire

population, but also in terms of the response of the people involved to these problems. It places emphasis on social meaning of epidemiological parameters of a health problem (Banerji 1986a:95-105). These epidemiological and sociological data are then used to determine the choice of technology and type of the administrative system needed to make the chosen technology accessible to the people. As against the conventional approach of subordinating people to a predetermined package of technology, here it is the technology which is subordinated to meet the needs of the people: the approach of New Public Health requires a social orientation of technology. These basic postulates of practice of New Public Health have been included in the Alma Ata Declaration (World Health Oroganization 1978): intersectoral action for health; promotion of community self-reliance by strengthening people's capacity to cope with their health problems; social control over health services; use of technology which is appropriate to the prevailing social, cultural and economic conditions; integration of promotive, preventive, curative and rehabilitative services; and ensuring coverage of the entire population.

Elements such as modes of production and production relations, social and economic structure and epidemiological situation go into the formation of the foundation, which determines the architecture of the edifice of health service system. Practice of New Public Health involves development of a health service system which, within the existing constraints, most effectively deals with the health problems confronted by the people.

Considerable progress has been made in generating knowledge for New Public Health in India. Colonial conquest and formation of the colonial pattern of health services, which continued to be perpetuated by the leadership of the post-colonial period and a parallel development of concepts and practices for people oriented health services, which culiminated in the decision to entrust 'peoples' health in peoples' hands' provide a historical backdrop. Work at the National Tuberculosis Institute at Bangalore (Chakraborty 1979; Banerji 1985: 136-42) provided a framework for developing nationally applicable, socially acceptable and epidemiologically effective health programmes of the country. Study of political economy of population control has led to a strong advocacy for generating motivation for small

family norm through socio-economic development (Government of India 1980). It has been possible to generate enough knowledge to launch academic programmes based on New Public Health. Reacting to the political and social issues raised, there has also been a counter movement. The Universal Child Immunization Programme represents an effort to go back to the old approach of imposing on people technocentric, dependence promoting, vertical programmes.

XI

STRENGTHENING OF PUBLIC HEALTH PRACTICE

The long neglect of the critical importance of public health practice in health service development has caused serious damage. The 1982 Statement on National Health Policy (Government of India 1982) had given a graphic account of the damage. It also contains a policy perspective of what is to be done. But it does not provide any guidelines as to how the policy is to be implemented. There was also no follow up document to spell out the process of implementation of the national policy. Providing one more example of what Gunnar Myrdal (1968:20) has termed as a 'soft state,' probably the policy formulators, namely, the Government of India, and State Governments as well as the Parliament oand the State Legislatures were not very serious about implementing the policy. The events that have followed the adoption of the National Health Policy tend to support this assumption.

Since 1982, the generalist administrators become even more involved in the actual implementation of the family planning programme.As a result, the family planning programme became an even greater threat to development of the basic health services in rural areas, particularly in those states which already had a very weak health service infrasturcutre. In these states little was left to meet the basic health services needs of the people after the family planning programme got its pound of flesh in terms of target achievements. Health workers tended to relax

after they were able to meet the targets, partially or fully, as demanded by a coercive bureaucratic machinary. There was no corresponding pressure to ensure that the health workers also perform their other responsibilities. Generalist administrators were the pace setters in formulating the 250-crore Area Projects. Because of some major weaknesses in the project design and in their implementation, the Area Projects fell far short of the objectives (Bose 1985; Banerji 1985c). Again, some of the top scientists of India, who were assigned the task of formulating a strategy to eradicate leprosy by the turn of the century by the then Prime Minister of India, failed conspicuously in their task because they did not pay adequate attention to some fundamental epidemiological, administrative and sociological issues.

The technocentric, above-down programme of Universal Programme of Immunization (UPI) launched in 1985 is the very antithesis of the lofty ideals enunciated in the National Health Policy of 1982. Worse still, UPI is a very poorly designed programme. A programme of eradication of a communicable disease has been launched without even having a reasonably sound epidemiological data about the size, distribution and time trends of these diseases; without knowing the effecacy of the vaccines at the time of their administration, and without realising the stupendous logistic problems involved and the possible consequences of insisting on immunization targets on the building up of an infrastructure for providing health for all by the turn of the century. The fact that there was so little analysis of this programme by scholars in public health in the country provides yet another instance of the poor state of public health.

The political leadership has presided over this wanton desecration of the health services. They have grossly neglected the need to maintain a high quality of public health practice. By placing square pegs in round holes at key places in the health administration, they have shown cynical indifference to the vital interests of the people whom they are supposed to represent. Political nepotism and corruption has become almost a bye-word, both with the public as well as those who work in different health institutions. The Lentin Commission's report (Editorial 1987) on the recent suspicious deaths of patients in the J.J. Hospital in Bombay shows that corruption and nepotism has infiltrated to the highest levels even in the most prestigious institution in one of the more 'advanced' states of the country.

The only redeeming feature is that this precipitous decline in the quality of public health practice is fast nearing the rock bottom and that this might jolt the political leadership into taking the urgently needed remedial steps. Hopefully, peoples' patience with the excesses committed by their own government and the with the governments' failure to fulfil the promises made, may also be reaching yet another boiling point.

Political leaders may thus be compelled to act. But if they do so, they will find it a daunting task. Repair of the damage done and reconstruction is much more difficult. Such political action has to be taken in three phases: stopping further sliding down of the quality of public health practice; regaining the competence in public health practice shown by the members of the IMS, as in the setting up of the PHCs and implementing NMCP and NMEP; developing the competence further to be able to practise New Public Health.

Some apparently simplistic efforts have been made to strengthen public health practice by seeking assistance from institutes of management. Strengthening public health workers was a component of the design for the India Population Project-I of 1971-76 and the succeeding IPP-II of the Area Projects of 1980-85 (Maru et al 1983). The results were not encouraging. The experience with the Area Project of Orissa, in which consultants from the Liverpool School of Tropical Medicine participated to strengthen the education and training of nurses and multipurpose workers, as a part of contributions form the British Overseas Development Agency, has shown that assistance from foreign countries is of very limited relevance to under the conditions prevailing in Orissa (banerji 1985c). This experience also showed that this involvement of experts from abroad did not bring out any strikingly original ideas, concepts and methods for health service development during their five years of work. This is in line with many other experiences of the past (Banerji 1985a: 243). While participation of scholars from abroad, as equal partners, ought to be welcomed as they may open up fresh perspectives, essentially Indians have to find Indian solutions to their country's health problems. Experiences at the National Tuberculosis Institute, or at the National Institute of Health Administration show how scholars from abroad ought to join hands with their Indian counterparts to tackle community health problems.

Considering the very special nature of the problems and special socio-economic conditions and political commitments, by and large, the solutions must emerge from within the country itself. The ideas must be endogenous. It has been seen again and again, for instance, in the different phases of the development of family planning programme and in the practice of health education (Banerji 1985a: 243-47; Banerji 1986a:47-60) that mere grafting of concepts and methods borrowed from industrialised countries is not very productive; often it is downright counter-productive.

Radical actions are needed to improve public health practice in India. These actions need not be taken all at once. They could be a part of a strategy, with its short term and long term objectives. A broad outline of the strategy is presented below:

1. The political leadership has to play a more active role in improving the administrative climate and in health manpower development. An immediate step in this direction will be to put an end to the practice of political interference in the routine administration of the health services at the Centre and in the states. Obviously, this cannot be done unless there is change in the overall culture of the political leadership in the country. Public office must be used for the public good, and not as a means of illegal accumulation of wealth and political patronage (see Editorial 1987). This cannot be inculcated through leadership development progoramme, as was often done in the past. This will emerge as a part of the process of democratisation of the people. It will require a higher level of political conciousness and social responsibility on the part of the political leaders and much greater degree of public vigilence. It will require a 'cultural revolution' It may be emphasised once again that it is not being contended that no action can be taken till there are far-reaching changes in the political situation. The existing political situation in different parts of the country can be taken and given as a constraint. This still leaves considerable scope for strengthening public health practice in India. Simultaneously, effort ought to be made to minimise this constraint by emphasising repeatebly that the process of health service

development depends very much on the degree of democratisation.

2. Another immediate possibility for political action will be to prohibit the direct involvement of generalist administrators in policy formulation and programme development, implementation and evaluation and research. The generalist administrators are meant to carry out general administration. It is the director-general of health services who should directly advise the minister of health on all technical issues and be responsible for the execution of the technical programmes in the ministry of health and family planning programme, as was the case at the time of Independence. Indeed, the director-general at the Centre and the director of health services in the State of West Bengal also served as the health secretary to the respective governments. Once it is possible to have professional personnel with adequate competence in health administration, revival of this practice could also be considered. It is not being contended that IAS officers can not contribute to health administration and that they should be actively shunned. They should be given responsibility only for the tasks for which they are qualified and they are held accountable for their action. They should not automatically be given superior positions simply because they happen to belong to the IAS; nor are they allowed to jump randomly from one ministry to another without being held accountable for their actions. As recommended by the Administrative Reforms Commission (Government of India 1969), they should belong to a group of officers who have chosen health services for their career planning.

3. An important cause of the increase in the dominance of generalist administrators in a ministry of health is the abolition of the IMS cadre, and not replacing it with an alternative all-India cadre. Repairing of this damage will require a major initiative from the political leadership. It will have to build up a critical mass of highly competent professional health administrators who can take action to suitably fill the

768

COMMUNITY HEALTH CELL
47/1, (First Floor) St. Marks Road.

vacuum when the role of generalist administrators is circumscribed.

4. One of the tasks before the critical mass of health administrators will be to examine the feasibility of an all-India cadre of health services. There are also various alternative possibilities, such as confining the cadre only to health administrators and not including teachers and specialists or building an integrated cadre including only those states which are willing to participate in it, and so forth. If, at least for the time being, it is felt that there is no alternative to the existing cadre of Central Health Service at Union health ministry, steps may be taken to rectify the serious flaw in the cadre structure because of fewer positions and still fewer oportunities for gaining experience and promotional avenues for health administrators by inducting suitably qualified persons from the states at key positions requiring expertise in health administration. In the absence of an all-India cadre, the states can still take corrective measures by expanding the positions for health administrators, to ensure that the personnel occupy key positions in health administration only after they have acquired enough experience at the block, district, regional and state levels and they have undergone suitable reorientation and staff college training and had taken courses in continuing education in new public health.

5. Development of manpower to suitably fill the critical positons in health administrationat the Centre and in the States will have a very high priority. It will require rejuvination of some of the key instutions for education, training and research such as the All-India Institute of Hygiene and Public Health, the National Institute of Health and Family Welfare, the National Institute of Communicable diseases, the National Tuberculosis Institute, the National Institute for Research and Training in Leprosy and the National Institute for Occupational Health. Here, the action will be in the form of faculty development and training, curricular development and development of suitable pedagogic approaches to education and training of different categories to meet

the needs of health administration in the country. Such manpower development can be carried out at two different levels. One would be aimed at raising competence in health administration to the level which existed at the time of Independence, so that they can more effectively implement many of the existing programmes, such as rural health programmes at sub-centre, PHC, taluk/tehsil and district levels, the Health Guides' Scheme, the programmes for control/eradication of communicable diseases, administration of hospitals and other medical care organizations, and so forth. The other level lies still higher in the form of producing practioners of New Public Health - in the formation of Managerial Physicians, who have epidemiological, managerial, politicl and social competence to build up health programmes that start from the people, rather than being mere collection of technocentric programmes that are thrust on the people.

6. When it is possible to make significant progress in developing this pattern of manpower for health service development, it will not be very difficult to bring about a fundamental reorientation of undergraduate and post-graduat education of physicians and other health professionals.

7. With the background of the possible steps that can be taken to strengthen public health practice in India, it is possible to define the contours of a suitable service cadre. It is presumed that medical education would undergo the radical changes needed for producing what the Bhore Committee had called a social physician. There will be corresponding changes in post-graduate medical education, particularly those associated with education and training of community health workers. Faintly echoing the career planning of the IMS and also of the ICS, the suggested cadre visualises a mandatory experience as general duty health officers in urban or rural areas for all the persons of all the categories of health services. The duration could be anything from two to six years. They can then branch into anyone of the three streams. There will be one

predominantly 'line' stream, where the persons will grow up as a Managerial Physician, taking up positions at the block, tehsil/taluk/sub-divisional, district, state and central levels. Hospital and medical care administration, municipal health administration, institutions for education and training of health workers and some research institutions will be staffed by members belonging to this stream. As he progresses in the cadre, he acquires post-graduate education in community health, besides getting reorientation training and continuing education at intervals. Staff college training at NIHAE is mandatory for those who go on to occupy key positions in health administration. The other two streams in the cadre are almost exclusive 'staff' streams. Members choosing one of them will be filling the posts of specialists of various kinds within the health services. Those belonging to the other stream will be for teaching posts in medical colleges and post-graduate institutions. In the case of these two streams also the members will obtain postgraduate qualification and attend programmes for continuing education and reorientation from time to time. Each of the three streams of the cadre will become almost exclusive, with proportionate possibilities for promotion in their own stream. There will be little scope for lateral mobility. At the very top of a stream, if a conscious decision is made to place a person from either of the two 'staff' streams to the top position of the director-general in the 'line' stream, then the chosen person will have to undergo a staff college course before he takes over the charge. At lower levels in the cadre, lateral change of a stream is allowed only when the member acquires the qualification required for entry into another stream.

SUMMARY

A description and an analysis of trends in public health practice in India involves consideration of the process of generation of health problems and the socio-cultural and

political response to them, both in time and in space. The time dimensionn covers a span of over a century and a half. There are four major 'spatial' elements within this time flow: (a) There is the issue of rapid increase in the coverage by community health services, in terms of population as well as health problems; (b) almost the entire growth and development of knowledge of medical science and technology has taken place during this period; (c) the requirements for extending the coverage and for incorporation of the newer technologies have brought about major changes in the concepts and methods of public health practice; and (d) an increasing process of democratisation among the massses of people had made it increaingly difficult for the rulers to avoid meeting at least area of the health services needs of unserved and undeserved sections of the population. An attempt has been made to blend aspects of these time and space elements to work out an integrated account of public health practice in different phases of its history.

From an anthropological standpoint, the history of health service development in India is an account of the interaction of the Western system of medicine to the degree to which it is made accessible to different sections of the population on the one hand and the pre-existing system of medicine which the people have developed for themselves in the course of the development of their ways of life (i.e., their cutlure), on the other. The most powerful motive force for the in introduction of Western medicine in India and formation of a health service system was to reduce the appallingly high mortality rates among the British troops and other rulers of this part of the Empire. There has been an ubabashed practice of racial discrimination in giving access to health services. After Independence, this racial discrimination was replced by more subtle form of class discrimination. There was one pattern of public funded health service for the upper classes, while there was a service which was they were much inferior and more difficult of access for the vast masses of people.

The British rulers formed the Indian Medical Service to serve as the backbone of colonial pattern of the health services, which included institutions for medical care, public health, research and education and training of different categories of health workers. However, the very process of health service development based on a monopolistic control of the IMS had a contradiction built into it. The increasing nummber of Indian

physicians, who were not in the IMS, started to resent this denial of access to the key positions in the public institutions. Some of them joined the national movement and used it to ventilate their grievances against this 'injustice'. One of the first actions of the Ministry of Health of independent India was to abolish the cadre of the Indian Medical Service. There was a fatal flaw in this decision inasmuchas it was not followed up with an alternative all-India cadre of health services which could effectively meet the much more difficult challenge of the rapid qualitative and quantitative expansion of the health services that followed Independence. There has also been considerable increase in the scope of practice of public health, involving interdiscilinary efforts to develop an epidemiological approach to solving a community health problem, use of complex methodological approaches, such as operational research and systems analysis, and relating health services to the overall socio-economic developmental process. Managerial Physicians, who have high levels of epidemiological, managerial, social and political skills, were required to perform this talk. Instead, there was a sharp decline even from the levels developed by the IMS.

The political leadership of the ministries of health and family planning at the Centre and in the states are to be squarely held responsible for the sharp deterioration in the quality of public health practice in the country. Through their ill-conceived decisions concerning personnel management, they have allowed precipitous decline in the functioning of some of the key institutions, e.g., the All India Institute of Hygiene and Public Halth, the National Institute of Health Administration and Education, the National Tuberculosis Institute and the directorate of health services at the Centre and in the states. As a consequence, there have been serious defects in the conceptualisation, formulation and implementation of almost all the major components of the health service system of the country. These defects have been underlined in Statement on National Halth Policy of 1982.

Considering that the complex, interdiscilinary nature of health service development requires much more extensive involvement of Managerial Physicians, generalist (IAS) administrators in the ministries of health ought to have correspondingly been phased out. However, presumably because of the vacuum created as a result of failures of public health

institutions. the generalist administrators were allowed by the political leadership to vastly expand their areas of influence and take decisions for which they are certainly do not have the training and expereince. It started with the taking over of the family planning and maternal and child health programmes from the directorate-general of health services, under a separate Department of Family Planning in the Union Ministry of Health and Family Welfare. Expectedly, the programme failed to yield the desired demographic results. The law and order approach adopted by the generalist administrators also played havoc with the rural health services. The programme remains the darkest and the largest blot on the landscape of the health services in India. The generalist administrators had also taken over the task of providing leaership for the Community Health Workers' Scheme, the Area Development Ptojects for health and family welfare and the Universal Programme of Immunization. The results have been far from satisfactory.

Action to strengthen public health practice must start from the political level. Formation of an all-India cadre or at least strengthening of the existing cadre of Central Health Services is urgently called for. To improve the quality, it would be necessary for the political leadership to actively search for highly intellegent and dedicated public health workers and obring them together to form a 'critical mass', which could strengthen the key institutions for practice, research, education and training in public health.

REFERENCES

1. Baily, G.V.J. (1980): Trial of BCG Vaccines in South India for Tuberculosis Prevention, Indian Journal of Medical Research, Vol. 72, Suppl., July, pp. 1-74.

2. Banerji, D. (1971a): Fainly Planning in India: A Critique and a Perspective, New Delhi, People's Publishing House.

3. Banerji, D. (1971b): Tuberculosis as a Problem of Social Planning in India, NIHAE Bulletin, Vol. 4, No. 1, pp. 9-25.

4. Banerji, D. (1975): Social and Cultural Foundations of Health Services Systems of India, Inquiry 12(2): 70-85.

5. Banerji, D. (1984): Political Economy of Western Medicine in Third World Countries in McKinlay, J.B. (ed.): Issues in the Political Economy of Health Care, London, Tavistock.

6. Banerji, D. (1985a): Health and Family Planning Services in India: An Epidemiological, Socio-Cultural and Political Analysis and a Perspective, New Delhi, Lok Paksh.

7. Banerji, D. (1985b): Bhopal Tragedy and Sarkari Scientists, Economic and Political Weekly, Vol. 20, No. 32, August 10, p. 1330.

8. Banerji, D. (1985c): Some Observations on Implemenation of the Area Projects, New Delhi, CSM&CH, J.N.U. (Mimeo).

9. Banerji, D. (1986a): Social Science and Health Service Development in India: Sociology of Formation of an Alternative Paradigm, New Delhi, Lok Paksh.

10. Banerji, D. (1986b): Hidden Menace in the Universal Child Immunization Programme, Journal of the Indian Medical Association, Vol. 84, No. 8, August, pp. 229-232.

11. Basu, B.N, J. Jezek and N.A. Ward. (1979): The Eradication of Smallpox from India, Geneva, WHO (WHO Regional Publications -South- East Asia Series, No. 5).

12. Bose, A. (1985): Demography Beyond Decimal Points: Presidential Address, 10th Annual Conference of the Indian Association for the Study of Population, Bangalore, Indian Institute of Management.

13. Bose, A. (1986): Population Stabilisation through Bureaucratic Targetism or Social Transformation: Presidential Address Elevent Annual Conference of Indian Association for the Study of Population, Varanasi, Indian Association for the Study of Population.

14. Bose, A. (1987): For Whom the Target Tails? A Critique of Family Planning Incentives, Cash Awards and Targets: Presidential Address, XIIth Annual Conference of the Indian Association for the Study of Population, Allahabad, Allahabad University.

15. Chakraborty, A.K. (1979): Twentieth Anniverssary of NTI - What has the NTI achieved? NTI Newsletter, Vol. 16, No. 4, December, pp. 104-110.

16. Directorate General of Health Services (1981a): National Programme for Control of Blindness: Report for the Years 1979-80 & 1980-81, New Delhi, Ministry of Health and Family Welfare.

17. Dubos, R. and Dubos, J. (1952): The White Plague, Boston, Little Brown.

18. Editorial (1987): Waiting for Lentin Report, Economic and Political Weekly, Vol. 22, No. 52, December 26, pp. 2234-2235.

19. Fulop, T. and Roemer, M.J. (1982): International Development of Health Manpower Policy, Geneva, WHO (WHO Offset Publication, No. 61).

20. Gandhi, Indira (1981): Address to the Thirtyfourth World Health Assembly, New Delhi, Ministry of External Affairs, pp. 1-8.

21. Government of India (1940): Civil List, New Delhi, Director-General of Indian Medical Services.

22. Government of India, Health Survey and Development Committee (Bhore Committee) (1946a): Report, Vol. 1, Delhi, Manager of Publications.

23. Government of India, Health Survey and Development Committee (Bhore Committee) (1946b): Report, Vol. IV, Delhi, Manager of Publications.

24. Government of India, Special Committee on the Preparation of the NMEP into the Maintenance Phase (1963): Report (Chadha Committee Report), New Delhi, Ministry of Health and Family Planning.

25. Government of India, Committee on Administrative and Financial Aspects of the IUCD Programme (1966): Report, New Delhi, Ministry of Health and Family Planning.

26. Government of India, Committee on Integration of Health Services (1968a): Report, New Delhi, Ministry of Health and Family Planning.

27. Government of India, Committee on the Basic Health Services (1968b): Report, New Delhi, Ministry of Health and Family Planning.

28. Government of India, Administrative Reforms Commission (1969): Report on the Machinery of the Government of India and its Procedures of Work, Delhi, Manager of Publications, pp. 44-45.

29. Government of India (1970): Report of the Special Committee to Review the Working of the National Malaria Eradication Programme and to Recommend Measures for Improvement (Madhok Committee), New Delhi, Ministry of Health, Family Planning and Urban Development.

30. Government of India, Committee on Multipurpose Workers under Health and Family Planning Programme (1973): Report (Kartar Singh Committee), New Delhi, Ministry of Health and Family Planning.

31. Government of India (1976): National Population Policy, New Delhi, Ministry of Health and Family Planning.

32. Government of India (1977): Health Care Services in Rural Areas: Draft Plan, New Delhi, Ministry of Health and Family Welfare.

33. Government of India (1978): Annual Report, 1977-78, New Delhi, Ministry of Health and Family Welfare.

34. Government of India (1979): Draft National Health Policy, New Delhi, Ministry of Health and Family Welfare.

35. Government of India (1980): Working Group on Population Policy Report, New Delhi, Planning Commission.

36. Government of India (1982a): Report of the Working Group on Eradication of Leprosy, New Delhi, Ministry of Health and Family Welfare.

37. Government of India (1982b): Statement on National Health Policy, New Delhi, Ministry of Health and Family Welfare.

38. Government of India (1982c): Model Plan for Creation of Facilities and Provision of Services under Area Programme (Mimeo).

39. Government of India (1984): Annual Report, 1983-84, New Delhi, Ministry of Health and Family Welfare.

40. Government of India (1985): Universal Immunization Programme by 1990: Report of a Task Force, New Delhi, Ministry of Health and Family Welfare.

41. Government of India (1987): Annual Report, 1986-87, New Delhi, Ministry of Health and Family Welfare.

42. India Population Project, U.P. (1979): Newsletter, Vol. 1, No. 1, March.

43. India Population Project, U.P. (1978): Newsletter, Vol. 4, No. 3, May.

44. Leavell, H.R. (1965): Levels of Application of Preventive Medicine, pp. 14-38 In Leavell, H.R. and Clark, E.G. (ed), Preventive Medicine for the Doctor in His Community - An Epidemiological Approach, 3rd ed., New York, McGraw-Hill Book Co.

45. Leavell, H.R. (1968): Health Administrators in the Making, NIHAE Bulletin, Vol. 1, pp. 15-19.

46. McDermott, W. (1969): Demography, Culture and Economics and the Revolutionary Stages of Medicine, In Kilbourne, E.D. and Smillie, W.G. (ed): Human Ecology and Public Health, London, Macmillan, pp. 7-28.

47. McGavran, E.G. (1953): What is Public Health, Canadian Journal of Public Health, December, pp. 441-451.

48. McKeown, T. (1976): Role of Medicine: Dream, Mirage or Nemesis? London, Nuffield Provincial Hospitals Trust.

49. Marti-Ibanez, F. (1960): Henry Seigerist on History of Medicine, New York, M.D. Publications.

50. Maru, R. et.al. (1983): Management Interventions in Established Bureaucracies: A Case Study, Economic and Political Weekly, Vol. 18, No. 35, pp. M98-M110.

51. Myrdal, G. (1968): Asian Drama: An Enquiry into the Poverty of Nations, Vol. 1, New York, Twentieth Century Fund.

52. National Institute of Health Administration and Education (1971): What It is and What It Does? New Delhi, NIHAE.

53. National Planning Committee, Sub-Committee on National Health (1948): Report (Sokhey Committee Report), Bombay, Vora.

54. National Planning Committee (1949): Report, Chairman, Jawaharlal Nehru, Secretary, K.T. Shah, Bombay, Vora.

55. Pandit, C.G. (1982): My World of Preventive Medicine, New Delhi, ICMR.

56. Programme Evaluation Organisation (1970): Family Planning Programme in India: An Evaluation, New Delhi, Programme Evaluation Organisation.

57. Ramasubban, R. (1982): Public Health and Medical Research in India; Their Origin Under the Impact of British Colonial Policy, Stockholm, SAREC (Sarec Report R: 1982).

58. Rao, K.V. (1982): Study of Leprosy Control Programme in Rural Population in Chingleput District: unpublished Ph.D. Thesis, New Delhi, Centre of Social Medicine and Community Health, Jawaharlal Nehru University.

59. Rosen, G. (1958): History of Public Health, New York, M.D. Publications.

60. Roy, B.C. (1982): Future of the Medical Profession in India -Reprint of Presidential Address at the All India Medical Conference, Lahore, December 1929, Journal of Indian Medical Association, Vol. 78, pp. 24-30.

61. Seipp, C. (ed)(1963): Health Care for the Community: Selected Papers of Dr. John B. Grant, Baltimore, The Johns Hopkins University Press.

62. Sigerist, H.E. (1961): History of Medicine, Vol. 1, New York, Oxford University Press.

63. Singh, Karan (1975): Population, Poverty and the Future of India, New Delhi, National Institute of Family Planning.

64. Winslow, C.E.A. (1920): The Untilled Fields of Public Health, Science, No. 8, 51, pp. 23-33,

65. World Health Organization (1978): Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, September 6-12, 1978, Geneva, World Health Organization.

66. World Health Organization, Regional Office for South-East Asia (1985): The Concept of Health Services Research, New Delhi, WHO SEARO.

%#%#%#%#%#%#%#%#%#%